



WELLINGBOROUGH RURAL DISTRICT

ANNUAL REPORT

OF THE

MEDICAL OFFICER OF HEALTH

JOAN M. ST.V. DAWKINS
M.B., B.S., F.F.C.M., D.P.H., D.C.H.

1972

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WELLINGBOROUGH RURAL DISTRICT COUNCIL

Chairman of the Council:

COUNCILLOR B. A. J. TAYLOR.

Members of the Public Health & House Management Committee:

Chairman:

COUNCILLOR MISS E. M. THOMAS.

Vice Chairman:

COUNCILLOR D. C. HOCKING.

Councillors:

G. C. ADDIS, R. N. A. ALLEBONE, J. J. BRYAN, L. W. FIELDER, S. GRANT,
T. D. KEARSLEY (resigned 1.9.72.) G. F. J. MALLARD (elected 1.11.72.)
D. G. PAYNE (ex officio) B. A. J. TAYLOR (ex officio) G. P. TIMMS,
MRS. J. M. WETHERALL.

Clerk of the Council:

C. M. MAJOR, A.C.I.S.
(Resigned June, 1972)

D. ATKINSON, D.M.A.
(Appointed June, 1972)

Public Health Officers of the Council:

JOAN M. ST. V. DAWKINS, M.B., B.S., F.F.C.M., D.P.H., D.C.H.

Medical Officer of Health
Division 1, Northamptonshire.

(Boroughs of Brackley and Daventry; Urban District Council of
Wellingborough; Rural Districts of Brackley, Brixworth,
Daventry, Northampton, Towcester and Wellingborough.)

Senior Assistant County Medical Officer of Health.

Secretary:

MRS. E. STEVENSON.

Chief Public Health Inspector, Meat Inspector etc.:

G. H. COWLES, Certified S. I. B., M.A.P.H.I. L. A. SCHOFIELD, Certified
(Retired August, 1972) S.I.E.J.B., M.A.P.H.I.
(Appointed August, 1972)

Additional Public Health Inspector:

P. M. SMITH, Dip.P.H.I.E.B., M.A.P.H.I.
(Appointed August, 1972.)

Telephone:
Northampton 34833
Ext. 335

Divisional Health Office,
7 Cheyne Walk,
Northampton. NN1 5PT.

To: THE CHAIRMAN AND MEMBERS OF THE
WELLINGBOROUGH RURAL DISTRICT COUNCIL

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report as Medical Officer of Health, which also incorporates the Report of the Chief Public Health Inspector.

The Report is presented once again in eight sections, the first seven dealing with an aspect of the control of the environmental health of the area and the final section containing a number of statistical tables.

The vital statistics for the year show that there was an increase in population of 860 according to the Registrar General's mid-year estimate of 19,570. There were 167 deaths, a decrease of 26 on last year's figure. This gives a standardised rate of 9.1 compared with the national figure of 12.1. Male deaths exceeded female deaths by 17. The total number of live births was 398, the same as last year, and giving a standardised rate of 17.3 compared with the national figure of 14.8. Illegitimate births were 11, eight less than in 1971. There were 8 deaths under the age of one year, 7 occurring in the first week of life.

The first section (A) dealing with national and social conditions indicates that the district remains virtually unchanged with tanning, boot and shoe, plastics, animal feeding stuffs, flour milling, fertilisers, light industry and agriculture continuing as the main occupations. In this section statistics of births and deaths and consideration made of the causes of early and preventable deaths are given. While the annual report relates to local environmental health it would be incomplete without some reference to the personal health of individuals living in the area. The section includes comments on cancer, arterial disease, a study on road accidents and details of a R.O.S.P.A. report on home accidents.

The second section (B) outlines health and social services, both statutory and voluntary, which are provided in the district. Services given, particularly to the elderly, on a voluntary basis make a valuable contribution to the community life, and gratitude to those who give so unstintingly of this constant help is expressed.

The third section (C) deals with sanitary circumstances giving a description of water supplies, sewerage, refuse collection and disposal, rodent

control and other health functions. The Irchester Phase II Sewerage Scheme was completed and instructions given for the preparation of Irchester Phase III. It is anticipated that work on the Mears Ashby/Earls Barton Scheme and on the connection of six dwellings in Wollaston to the main sewerage will commence in 1973. Planning approval has been obtained for a pumping station at the existing Sywell Sewage Disposal Works. In addition, the Consulting Engineers are preparing a scheme for the connection of Little Irchester sewage to the Wellingborough Urban District sewers and the Wollaston Regional Sewage Scheme is being prepared for formal submission to the Department of the Environment. Future environmental health control, after reorganisation of services, is also considered.

The fourth section (D) is concerned with council housing, giving an account of slum clearance, (521 unfit houses have been cleared, while 75 remain), council house tenancies, improvement grants and other matters. The Chief Public Health Inspector of this authority is also the Housing Officer, and is responsible for the organisation of council house allocation. In 1972 two bungalows and eight flats were completed by the Council. 170 houses were provided by private enterprise.

The fifth section (E) deals with food hygiene, which continues to be a major concern of health departments. Changes due to technical advances in the food industry, while greatly improving variety and keeping quality, do not lessen, but rather increase the need for vigilance in food control. Innovations in manufacture, storage and cooking, together with increasing mobility of the population (including travel abroad and the importation of infections), demand constant control. The ultimate responsibility, however, always remains with the actual food handlers, and the rapid turnover of employment, together with these other factors require supervision from both employer and inspector. Finally consumers, themselves on the alert, should refuse to accept unsatisfactory practices.

The sixth section (F) deals with control of infectious and other diseases in the district. The only notifications received were two of tuberculosis and 14 cases of food poisoning 13 of these occurring in one school. 4 people died from pneumonia and 3 from bronchitis. There were no cases of measles compared with 55 in 1971. Measles vaccination increased considerably in the country. It is to be hoped that from henceforward with the availability of vaccines and the use of the computer, that a higher percentage of children will be vaccinated. While at present the incidence of infectious illness remains satisfactory low, should succeeding generations of parents fail to respond to the need for immunisation, recrudescence could occur. It remains vitally important therefore for children to be immunised for diphtheria, poliomyelitis, whooping cough, tetanus and now measles, tuberculosis vaccination following later in the early teens. Rubella (German Measles) vaccination is also available to all girls between the ages of eleven and fourteen.

The seventh section (G) deals with the Factories Act, 1961 and the Offices, Shops and Railway Premises Act, 1963, and the final section (H) contains a list of statistical tables.

The year was notable for the proposed legislation for the reorganisation of Local Government, the National Health Service, and the Water Authorities, which are timed to coincide in April 1974. The office of Medical Officer of Health will cease, and instead those at present practising in the public health field will join the National Health Service as part of the new discipline of community medicine. Local authorities will no longer employ doctors, but medical advice will be obtained from community physicians. As the envisaged changes are of historic importance I have attached to this report an appendix which outlines the future role of the community physician and gives some detail of the structure of the reorganised National Health Service, considering also some of the perspective of the changes in health legislation during the century of the practice of public health.

While this report will be my last to this Council, and the penultimate one on the health of the district (which will be presented to the enlarged District Council in 1974) I considered it appropriate to present this detailed account of the changes, and at the same time to express the hope, that with adequate collaboration arrangements the future medical advice which will be available to local authorities will be both sought and given as freely and with the same accessibility between doctor, officers and councils of local authorities as when the Medical Officer of Health held office as a statutory appointment.

On a personal note I had the honour to hold office as Chairman of the Northampton division of the British Medical Association; was appointed Chairman of the Oxford Region of Public Health Medical Officers for the fifth year, and represented that Region, again for the fifth year on the Public Health Committee of the British Medical Association. I was also again appointed to the Whitley Council Staff Side.

I would like to pay my tribute to the Council who have always sought high standards in public health and shown interest in the preventive health field. I give thanks for the personal kindness and co-operation I have received from Councillors and Officers. Mr. G. H. Cowles, after 36 years of long and steadfast service as Public Health Inspector, retired in July 1972 and Mr. L. A. Schofield became Chief Public Health Inspector. with Mr. P. M. Smith appointed as Additional Public Health Inspector. I express the wish that the long, cordial and successful association already established with the Public Health Inspectors will be maintained in the same happy vein under reorganisation.

Finally I express my appreciation to the County Medical Officer of Health for his ready co-operation at all times.

I have the honour to be your
Obedient Servant,

JOAN M. ST. V. DAWKINS

Medical Officer of Health.

A C K N O W L E D G E M E N T S

I wish to express my thanks to the following for information supplied and contained in this Report:-

CLERK OF THE COUNCIL

ENGINEER AND SURVEYOR

TREASURER

CHIEF PUBLIC HEALTH INSPECTOR
AND HOUSING OFFICER

ENGINEER TO THE HIGHAM FERRERS
AND RUSHDEN WATER BOARD

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SUMMARY OF VITAL STATISTICS

Comparative Statistics for the Five Year Period 1968 to 1972

	1968	1969	1970	1971	1972
Area of the Rural District (acres)	33,116	33,116	32,707	32,707	32,707
Population (Registrar General's Estimate)	15,720	16,350	17,130	18,710	19,570
Number of Live Births ..	288	319	378	398	398
Legitimate	275	306	364	379	387
Illegitimate	13	13	14	19	11
Birth rate per 1,000 pop. ..	18.32	19.5	22.10	21.3	20.3
Number of Stillbirths ..	2	2	6	6	2
Legitimate	1	2	5	6	2
Illegitimate	1	-	1	-	-
Stillbirth rate per 1,000 total births	6.9	6.2	16.00	15.00	5.00
Stillbirth rate per 1,000 population	0.13	0.12	0.35	0.32	0.10
Number of Deaths	182	188	212	193	167
Death rate per 1,000 pop. ..	11.58	11.49	12.40	10.30	8.5
Deaths from Pregnancy, Childbirth and Abortion	-	-	-	-	-
Number of Infant Deaths ..	6	4	4	11	8
Infant Mortality rate per 1,000 Live Births	20.83	12.53	11.00	28.00	20.00
Neonatal Mortality rate per 1,000 Live Births	13.89	12.53	8.00	13.00	18.00
Perinatal Mortality rate (Stillbirths and deaths under one week combined per 1,000 total Live and Stillbirths) ..	17.24	18.69	23.00	25.00	23.00
Deaths from all forms of Tuberculosis	-	1	1	1	1
Deaths from Respiratory Tuberculosis	-	1	1	1	-
Deaths from Malignant Neoplasms	36	42	49	31	39
Deaths from Measles (all ages)	-	-	-	-	-
Deaths from Whooping Cough (all ages)	-	-	-	-	-
Deaths from Enteritis and Diarrhoea under two years of age	1	-	-	-	-
Deaths from Acute Poliomyelitis and Polioence phalitis ..	-	-	-	-	-
Natural increase in population, i.e. increase of Births over Deaths	106	131	166	205	231

SECTION A

Statistics and Social Conditions of the Area

Area (acres)	32,707
--------------	-----	-----	-----	-----	-----	--------

Census Population:

1951	13,002
------	--------

1961	13,647
------	--------

1971	18,425
------	--------

Population (Registrar General's Mid-Year Estimate 1972)	19,570
---	--------

Number of Inhabited Houses:

1931	3,558
------	-------

1972	7,044
------	-------

Rateable Value	£739,042
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Product of a penny rate	£7,070
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EXTRACTS FROM VITAL STATISTICS, 1972.

LIVE BIRTHS

					<u>Males</u>	<u>Females</u>	<u>Total</u>
Legitimate	198	189	387
Illegitimate ..	..	..	..	..	8	3	11
					<u>206</u>	<u>192</u>	<u>398</u>
Crude Birth Rate per 1,000 estimated population					..	..	20.3
Adjusted Birth Rate (Comparability factor .85)					..	..	17.3

STILLBIRTHS

					<u>Males</u>	<u>Females</u>	<u>Total</u>
Legitimate ..	..	..	..	..	2	-	2
Illegitimate ..	..	..	..	..	-	-	-
					<u>2</u>	<u>-</u>	<u>2</u>
Rate per 1,000 total births (live and still)					..	..	5

DEATHS

					<u>Males</u>	<u>Females</u>	<u>Total</u>
Number registered all causes ..	..				92	75	167
Crude Death Rate per 1,000 estimated population						..	8.5
Adjusted Death Rate (Comparability factor 1.07)						..	9.1
Deaths from Maternal causes ..	..	..	..	..	..	..	-
Maternal Mortality Rate per 1,000 live and stillbirths					..	..	-
					<u>Males</u>	<u>Females</u>	<u>Total</u>
Deaths of Infants (under 1 year) ..	..				5	3	8
Infant Mortality Rate per 1,000 live births					..	..	20
Legitimate Infants per 1,000 legitimate live births						..	18
Illegitimate Infants per 1,000 illegitimate live births					..	..	91
					<u>Males</u>	<u>Females</u>	<u>Total</u>
Deaths of Infants (under 4 weeks) ..	..				4	3	7
Neonatal Mortality Rate per 1,000 live births					..	..	18
Perinatal Mortality Rate per 1,000 live and stillbirths							
(stillbirths and deaths of infants under 1 week combined) ..						..	23

CLASSIFICATION OF CAUSES OF DEATH, 1972

List No.	Causes of Death	Sex	Total All Ages	Under 4 wks.	4 wks. & under 1 year	AGE IN YEARS								
						1+	5+	15+	25+	35+	45+	55+	65+	75 & Over
B6 (2)	Other Tuberculosis	M F	1 -	- -	- -	- -	- -	- -	- -	1 -	- -	- -		
B19(2)	Malignant Neoplasm, Oesophagus	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- 1	- -		
B19(3)	Malignant Neoplasm, Stomach	M F	- 3	- -	- -	- -	- -	- -	- -	- -	- -	- 3		
B19(4)	Malignant Neoplasm, Intestine	M F	2 1	- -	- -	- -	- -	- -	- -	1 -	- -	- 1		
B19(6)	Malignant Neoplasm, Lung, Bronchus	M F	9 4	- -	- -	- -	- -	- -	- 1	- -	2 1	5 1		
B19(7)	Malignant Neoplasm, Breast	M F	- 5	- -	- -	- -	- -	- -	- -	1 -	- 2	- 1		
B19(8)	Malignant Neoplasm, Uterus	F	1	-	-	-	-	-	-	-	1	-		
B19(9)	Malignant Neoplasm, Prostate	M	4	-	-	-	-	-	-	-	-	2		
B19(11)	Other Malignant Neoplasms	M F	4 5	- -	- -	- -	- -	- -	- 1	- -	2 1	2 1		
B21	Diabetes Mellitus	M F	2 1	- -	- -	- -	- -	- -	- -	- -	1 1	- 1		
B46(1)	Other Endocrine etc. Diseases	M F	- 1	- -	- -	- -	- -	- -	- 1	- -	- -	- -		
B23	Anaemias	M F	1 1	- -	- -	- -	- -	- -	- -	- -	- -	- 1		
B24	Meningitis	M F	1 -	1 -	- -	- -	- -	- -	- -	- -	- -	- -		
B46(5)	Other Diseases of Nervous System	M F	1 -	- -	- -	- -	- -	- -	- -	- -	- -	- -		
B26	Chronic Rheumatic Heart Disease	M F	1 1	- -	- -	- -	- -	- -	- -	- -	1 -	- 1		

List No.	Causes of Death	Sex	Total All Ages	Under 4 wks.	4 wks. & under 1 year	AGE IN YEARS								
						1+	5+	15+	25+	35+	45+	55+	65+	75 & Over
B27	Hypertensive Disease	M F	1 4	- -	- -	- -	- -	- -	- -	- -	- -	1 -	- -	- 4
B28	Ischaemic Heart Disease	M F	28 18	- -	- -	- -	- -	- -	- -	- -	- 1	5 1	13 2	10 14
B29	Other forms of Heart Disease	M F	1 4	- -	- -	- -	- -	- -	- -	- -	- -	- -	1 1	- 3
B30	Cerebrovascular Disease	M F	8 10	- -	- -	- -	- -	- -	- -	- -	- -	1 1	3 1	4 9
B46(6)	Other Diseases of Circulatory System	M F	8 5	- -	- -	- -	- -	- -	- -	- -	- -	1 1	4 -	4 4
B31	Influenza	M F	2 2	- -	- -	- -	- -	- -	- -	- -	- -	- -	2 -	- 2
B32	Pneumonia	M F	2 2	- 1	- -	- -	- -	- -	- -	- -	- 1	- -	1 1	- 1
B33(1)	Bronchitis and Emphysema	M F	2 1	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	2 1
B34	Peptic Ulcer	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- -	- -	1 1	- -
B36	Intestinal Obstruction and Hernia	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- 1
B46(8)	Other Diseases of Digestive System	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- -	- -	1 1	- -
B39	Hyperplasia of Prostate	M	1	-	-	-	-	-	-	-	-	-	1	-
B42	Congenital Anomalies	M F	4 -	2 -	- -	1 -	- -	- -	- -	- -	1 -	- -	- -	- -
B43	Birth Injury, Difficult Labour, etc.	M F	1 2	1 2	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -

(continued)

List No.	Causes of Death	Sex	Total All Ages	Under 4 wks.	4 wks. & under 1 year	AGE IN YEARS								
						1+	5+	15+	25+	35+	45+	55+	65+	75 & Over
B45	Symptoms and ill Defined Conditions	M	1	-	1	-	-	-	-	-	-	-	-	-
		F	-	-	-	-	-	-	-	-	-	-	-	-
BE47	Motor Vehicle Accidents	M	3	-	-	-	-	-	-	-	1	1	1	-
		F	-	-	-	-	-	-	-	-	-	-	-	-
BE48	ALL other Accidents	M	1	-	-	1	-	-	-	-	-	-	-	-
		F	3	-	-	-	-	-	-	1	-	2	-	-
<u>TOTAL ALL CAUSES</u>			92	4	1	2	-	-	-	-	3	15	36	31
		M	75	3	-	-	-	-	-	4	3	9	10	46
		F												

SECTION A

NATURAL AND SOCIAL CONDITIONS

The rural district situated on the eastern side of Northamptonshire with the River Nene flowing through its area, has in its centre the growing urban district of Wellingborough. There has been a marked population increase in the last five years. The district remains virtually unchanged with tanning, boot and shoe, plastics, animal feeding stuffs, flour milling, fertilisers, light industry and agriculture continuing as the main occupations.

The area of the district is 32,707 acres, giving an average of one person to 1.67 acres and the housing factor is 2.78 persons per house.

The Registrar General's Mid-Year Estimate gives the population for 1972 as 19,570 an increase of 860 on the population of the previous year, due mainly to private enterprise building. The natural increase in the population, that is the excess of births over deaths was 231.

BIRTHS:

The number of births was 398 the same as last year, giving a standardised rate of 17.3 calculated on the comparability factor of .85 as against 14.8 for England and Wales per 1,000 of the total population.

STILLBIRTHS:

The total number of stillbirths in 1972 was 2, compared with 6 in 1971. The stillbirth rate is 5.00 per 1,000 total births compared with 12.00 for England and Wales. Particulars of these stillbirths are given below:-

<u>Sex</u>	<u>Cause.</u>
M	Placental insufficiency
M	Hydrocephaly

ILLEGITIMATE BIRTHS:

There were 11 illegitimate births in 1972, 8 less than in 1971.

MATERNAL MORTALITY

No death was recorded.

INFANT MORTALITY:

The number of children under one year who died was eight, in 1971 there were eleven. Seven of these deaths occurred in the first week of life, which is known as Early Neonatal Mortality, the rate for 1972 is 18.00 per 1,000 live births, the current rate for England and Wales is 10.00.

The causes of Infant Deaths with age and sex were as follows:

<u>Age</u>	<u>Sex</u>	<u>Cause of Death</u>
1 hour	M	Multiple congenital anomalies
7 hours	F	Prematurity, respiratory distress syndrome
3 days	M	Heart failure, congenital heart disease
3 days	M	Neonatal meningitis
4 days	F	Pneumonia
5 days	F	Cerebral haemorrhage
6 days	M	Perinatal anoxia
4 months	M	Sudden death in infancy syndrome

DEATHS:

There were 167 deaths from all causes in 1972. The figure for last year was 193 and the corresponding Crude Death Rates are 8.50 and 10.30. The standardised rate is calculated from the Registrar General's comparability factor for the district which is 1.07, this makes an allowance for age and sex distribution of the population in different areas and is adjusted specifically to take into account the presence of any residential institutions in the area.

Out of a total of 167 deaths, 44 died before the age of 65 and a further 46 between 65 and 74, making a total of 90 before the age of 75. Of these 90 deaths, 61 were males and 29 were females. Premature death is caused mainly by accidents, arterial disease and the cancers. In the district there were three deaths as a result of motor vehicle accidents involving 2 males under age 45 and one male aged between 65 and 74. Of the total 89 deaths from diseases of the heart and circulation, 8 males and 3 females died before the age of 65, 21 males and 4 females between the ages of 65 and 74. The cancers took a total of 39 deaths, 26 of these before the age of 75. Nine males and four females died from cancer of the lung.

EARLY AND PREVENTABLE DEATH AND MORBIDITY:

DEATHS FROM CANCER

Lung Cancer and Cigarette Smoking

It is probable that cigarette smoking is the greatest contemporary health

problem. 50,000 deaths a year can be attributed to the habit. It is responsible for 9 out of 10 deaths from lung cancer (of which there were in 1972 31,649, 25,754 males, 5,895 females), 3 out of 4 deaths from chronic bronchitis and 1 out of 4 deaths from coronary artery disease. It is estimated that twenty times more work days are lost through sickness from smoking than on industrial disputes.

The adverse effects on health of smoking unfortunately only become manifest after many years, and are therefore not obviously connected with the habit. Also in many countries as the economic benefits from taxing tobacco products are large, governments have hesitated to change legislation, and it is not practicable to impose regulations on an unwilling population. However it is imperative to take action that will discourage young people from starting to smoke, and may promote reduction or abstinence in smokers. This includes keeping people constantly and fully informed about the health consequences of smoking and pressing for the curtailing of all forms of sales promotion that encourage the use of tobacco.

It has been suggested in a published paper* that the most important approaches to combat the health hazards of smoking are as follows:-

1. The education of youth not to take up smoking.
(In this respect all those adults who are associated with and have influence over young people should by the force of their own example discourage them from starting to smoke. These include parents, teachers, youth leaders, sportsmen, actors, pop stars and others whom young people admire and may emulate.)
2. The exerting of the influence of health workers.
(The medical profession have recognised the hazard, and now only a quarter of British male doctors smoke. Their death rate from lung cancer is now only 2/5th of the national figure.)
3. Group approaches to the control of cigarette smoking by adults.
4. Mass approaches to the control of cigarette smoking.
5. Reducing the effectiveness of the advertising and promotion of cigarettes.
6. Less hazardous smoking.

*Smoking and Health by Professor C. M. Fletcher & Dr. D. Horn.
WHO Publication.

Other Cancers

The causes of cancer, apart from cancer of the lung, remain still to be ascertained. However some progress is being made, and different methods of controlling the cancerous diseases have greatly increased in effectiveness in recent years. Research is providing information which will help in prevention, in early detection and treatment. New techniques for detection including mammography and xerography, cytology and immunodiagnosis are being used and further improved, while chemotherapy with carcinostatic drugs and hormones and perhaps immunotherapy in the future, may all prove to be new and effective chem-therapeutic agents. At present early detection and new and more effective treatment have restored numerous patients to lives of good quality for many years.

ARTERIAL DISEASE

The incidence of early degenerative arterial disease, particularly in men, has become the epidemic of civilisation, and presents with cancer, the major challenge to medicine today. The condition is manifest in either strokes or coronary thrombosis, and strikes men in their prime and at the time of their greatest contribution to society. The causes are multiple, and, as stated, cigarette smoking is probably a factor. As well as being part of the process of ageing hereditary factors are involved in some. Women are less affected until after the menopause, indicating a hormonal protection. The only clear evidence is that the incidence is lower in those who take regular physical exercise and who are not obese. This salient feature needs emphasis, as it is easy in a modern industrialised society with the majority occupied in sedentary occupations, the widespread use of motor transport and television, for many to become physically inactive. It is wise to establish a way of life soon after leaving school in which there is regular participation in physical exercise which can be suitably modified to the passing years. This combined with some moderation in the consumption of food, may help to prevent the early onset of arterial disease.

ACCIDENTS

ROAD ACCIDENTS

Definitions

A road accident is one involving personal injury, occurring on the public highway (including footpaths) in which a vehicle is concerned.

Killed means the person died at the time of injury or within 30 days

of the accident and because of it.

The various degrees of injury to a person depend upon the extent of the injury requiring hospital in-patient treatment and may be:-

- (i) Serious - such as fractures, internal injuries, severe shock etc.
- (ii) Slight - sprains, cuts and bruises.

Vehicles involved in accidents are those whose drivers or passengers are injured and vehicles which contribute to the accident, including horses being ridden at the time of the accident. Vehicles which collide after the initial impact are not included unless they aggravate the degree or amount of injury. Vehicles are classified according to their structural type:-

- (i) Pedal cycles - include children riding toy cycles and first riders of tandems (they make the decisions).
- (ii) Mopeds - two-wheeled motor vehicles of not more than 50 c.c. and equipped with pedals.
- (iii) Motor Scooters - two wheels with a platform for feet, open frame and wheels smaller than the conventional motor cycle.
- (iv) Motor cycles - again with two wheels and includes side-car/ combinations attached.
- (v) Cars, taxis (including minibus), goods vehicles, public service vehicles and electric milk floats.

Incidence

In 1972 359,792 were killed or injured on Britain's roads, an increase of 2% on 1971. Broken down this shows:-

7,779 killed - 1% more than in 1971
91,342 seriously injured - no significant change
260,671 slightly injured - 3% more than in 1971

Motor traffic was estimated as 5% higher than in 1971 (measured in terms of vehicle mileage).

The number of accidents is related to the amount of traffic. The doubling of road casualties over the past 20 years is related to the fact that during this time road traffic has TREBLED. When considered in respect of population the trend has been far less happy as road deaths have increased by 57% while population increase was 10%. The individual risk has now

increased from 150-1 to 100-1. Recent years have shown a growing proportion of casualties in the younger age groups:-

1:190 of 15-19 years killed each year				
1:790 of 40-49	"	"	"	"
1:725 of 60-69	"	"	"	"

The incidence in the younger age groups therefore constitutes 33 $\frac{1}{3}$ % of car driver casualties and 45% were riders or passengers of motor vehicles. The 40-49 age group were occupants, drivers and passengers, in cars ($\frac{2}{3}$ of total), and 60-69 were (four-wheel occupants) mostly as passengers in cars/buses.

Road Accidents involving Pedestrians

Pedestrians - including children (under 15 years) and adults - are children riding small cycles, people pushing bicycles or prams or other vehicles such as road sweepers, those leading or herding animals, occupants of invalid chairs or prams, and those who alight from vehicles and are subsequently injured or killed. The figures of accidents to children cause particular concern. One pedestrian in ten killed or seriously injured is aged four or less (for the first eighteen months of life they do not form part of the pedestrian population) indicating that nearly half the casualties are children.

The 60-69 group (elderly) suffer more than double the 40-49 years group. Compared with Western Europe, Britain has the highest pedestrian casualty rate, but for fatalities the figure is nearer the average. This factor is due to a great extent to the large number of pedestrians and the heavy traffic of built-up areas.

Causes of Accidents

1. Drinking alcohol to the extent of blurring judgement.
2. Not fastening seat belts when available.
3. Delaying repairs to vehicles and not performing routine checks on tyres, lights and brakes.
4. Driving too fast for road conditions - surface, lighting, type of area (30 m.p.h.), ice on roads, flooding, and in the summer polished road surfaces and skidding.
5. Leaving off lights well into the lighting-up time (half-an-hour after sunset and half-an-hour before sunrise). The accident rate is higher during the hours of darkness.

6. Getting impatient or starting a journey in a "bad temper".
7. Certain manoeuvres cause or contribute to accidents - e.g. turning right (particularly pedal cyclists - cause of 17% of these accidents). Indicating the opposite direction to that intended to take; brake or acceleration failure; badly parked and unlit vehicles; dog or other animal in the path of the vehicle; automatic level crossings; a disobeyed junction control - a junction being any place at which two or more highways meet at whatever angle, including a roundabout and parts of such highways within 20 yards of the junction.

Action taken to improve Accident Rate

- 1934 - Road Traffic Act, introduced driving tests, 30 m.p.h. speed limit and pedestrian crossings.
- 1952 - There was a further reduction in accidents following the introduction of zebra stripes on crossings.
- 1964 - Seat belts for the front seats of motor cars were introduced and to encourage greater use all new cars registered after 1st April, 1973 are required to have the latest design of seat belt available which can be fitted and fastened single handed.
- 1967 - Road Safety Acts, drinking and driving clauses stated for the first time that a person driving a motor vehicle would be guilty of an offence if he was shown to have a blood alcohol content above a prescribed level, that chosen being 80 m.g.m. alcohol per 100 ml blood. There was an immediate and remarkable drop in the accident rate following this legislation and the Act was continuing to have a marked affect at the end of 1972.
- 1971 - The Department put forward proposals to make the wearing of safety helmets for motor cyclists compulsory (this is now law) and has been shown to represent the biggest life saver.

The roads are constantly under surveillance and better road surfaces are being investigated. A 70 m.p.h. speed limit is in operation on motorways and depending on the road and the area through which it runs there are speed limits of 30, 40 and 50 m.p.h. in operation. In cases of accidents, fog or other hazardous conditions provision has been made for alterations in the speed limit. Pedestrian bridges across very busy roads are being built. The radio and television are now used to give relevant information regarding roads and road users.

The police in conjunction with parents, education departments and organisations such as the boy scout movement, are teaching road safety.

Child cyclists are encouraged to take proficiency tests.

Motor vehicle standards are improving and research is continuous. Recently, because of the number of bad tyres on vehicles, the police have been carrying out spot checks and individuals can be fined if the tread of a tyre is below the stated requirement. Every vehicle of three years and over must have an annual test by a Certified garage and a statement issued indicating the vehicle is road worthy.

The Cost of Accidents

These are immeasurable in terms of pain, grief and suffering. Apart from this they represent a quantifiable loss to the community in economic terms which includes loss of output, cost of medical treatment, the time taken by police and courts, and the damage to property - this was estimated for a fatal accident at £13,000.00.

<u>Total Cost</u>		
Medical treatment, ambulance and funeral	-	£17 million
Police and administration	-	£28 million
Damage to vehicles and other property	-	£198 million
Lost output	-	£103 million
		<u>£ 346 million</u>

On average road accidents result in an economic loss of approaching £1 million per day, plus the human suffering involved which in money terms is unquantifiable.

HOME ACCIDENTS

During 1971 there were 6,245 accidental deaths in and around the home, 237 (or 3.7 per cent) fewer than in the previous year. Further analysis shows that the number of people who died in private homes fell by 117, and the number in residential institutions by 120.

SUMMARY

Cause of Death	Private Homes	Residential Institutions	Total Deaths
Poisoning	760	11	771
Falls	2824	1034	3858
Burns and scalds	656	33	689
Suffocation and choking	483	78	561
Others	334	32	366
TOTAL	5057	1188	6245

Every year more people die from falls than from all other accidents in the home, and as many as 62 per cent of the 6,245 fatalities in 1971 resulted from falls. Poisoning accounted for a further 12 per cent of the deaths; burns and scalds for 11 per cent, and suffocation and choking for 9 per cent. The remaining deaths were due to miscellaneous causes.

CAUSE, AGE-GROUP AND SEX

Cause of Death	Age-Group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 &+	Male	Female	
Poisoning	24	15	205	262	265	339	432	771
Falls	55	16	94	262	3431	1061	2797	3858
Burns and scalds	103	38	49	109	390	285	404	689
Suffocation and choking	301	18	77	82	83	333	228	561
Others	74	16	65	67	144	185	181	366
TOTAL	557	103	490	782	4313	2203	4042	6245
Death Rate*	14.2	1.3	2.6	6.6	67.4	9.3	16.1	12.8

*Deaths per 100,000 population.

Elderly people are especially prone to domestic accidents and this is reflected in the statistics - over two thirds of the victims were aged 65 and over. Children under five years old accounted for a further nine per cent of the total.

An alternative analysis of the data indicates that 65 per cent of the victims in 1971 were female.

FALLS

Cause of Death	Age-Group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 &+	Male	Female	
Falls on stairs	10	5	45	118	497	276	399	675
Falls from ladders	-	-	4	18	22	37	7	44
Falls from buildings	12	4	22	14	46	55	43	98
Other falls from one level to another	23	5	8	17	274	95	232	327
Falls on same level	-	-	4	12	352	72	296	368
Other and unspecified falls	10	2	11	83	2240	526	1820	2346
TOTAL	55	16	94	262	3431	1061	2797	3858

Accidental falls caused 3,858 deaths in the home during 1971. This is three more than in the previous year, but 34 fewer than in 1959 and 87 fewer than in 1968.

Women accounted for 76 per cent of the deaths among the over 65's but less than half the deaths in the remaining age groups.

POISONING

Cause of Death	Age-Group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 &+	Male	Female	
Barbiturates	-	-	78	148	104	123	207	330
Analgesics and antipyretics	4	1	16	8	2	14	17	31
Other sedatives	-	-	15	12	8	11	24	35
Nervous system and psychotherapeutic drugs	5	2	20	9	3	19	20	39
Other and unspecified drugs	4	2	12	13	6	18	19	37
Alcohol	-	-	9	15	5	16	13	29
Other solids and liquids	5	-	4	3	3	10	5	15
Total solids and liquids	18	5	154	208	131	211	305	516
Piped gas	1	6	30	34	98	79	90	169
Motor vehicle exhaust gas	-	-	9	7	1	17	-	17
Other carbon monoxide gases	4	3	12	10	32	29	32	61
Other gases and vapours	1	1	-	3	3	3	5	8
TOTAL gases and vapours	6	10	51	54	134	128	127	255
TOTAL	24	15	205	262	265	339	432	771

A total of 771 people died from accidental poisoning during 1971. This is 48 fewer than in 1970, 55 fewer than in 1969 and 107 fewer than in 1968.

A total of 169 people were accidentally poisoned by ordinary domestic gas in 1971, compared with 407 in 1968. The main reason for this improvement is the gradual introduction of natural gas which is non-toxic.

BURNS AND SCALDS

Cause of Death	Age-Group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 & +	Male	Female	
Ignition of clothing	4	7	5	18	108	38	104	142
Burns from controlled fire	3	1	1	9	65	31	48	79
Conflagration	79	28	30	49	111	144	153	297
Other and unspecified burns	7	-	11	28	73	55	64	119
TOTAL fire and flames	93	36	47	104	357	268	369	637
Hot substance, corrosive liquid and steam	10	2	2	5	33	17	35	52
TOTAL	103	38	49	109	390	285	404	689

There were 689 deaths from accidental burns and scalds during 1971, 111 fewer than in 1970, 76 fewer than in 1969 and 92 fewer than in 1968.

At least 77 of the 637 deaths from fire and flames were caused by matches and cigarettes, etc.

SUFFOCATION AND CHOKING

Cause of Death	Age-Group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 & +	Male	Female	
Inhalation and ingestion of food	170	4	43	58	71	193	153	346
Inhalation and ingestion of other objects	12	1	2	6	7	15	13	28
Suffocation in bed or cradle	92	-	3	3	1	57	42	99
Other and unspecified suffocation	27	13	29	15	4	68	20	88
TOTAL	301	18	77	82	83	333	228	561

A total of 561 people died from accidental suffocation and choking in 1971. This compares with 635 deaths in 1970, 651 deaths in 1969 and 649 deaths in 1968.

Nearly a third of the 561 deaths were caused by young children under five years of age choking over their food.

OTHER CAUSES

Cause of Death	Age-Group				Sex			Total Deaths
	0-4	5-14	15-44	45-64	65 & +	Male	Female	
Drowning and submersion*	33	2	14	12	24	46	39	85
Electric current†	7	5	31	15	12	47	23	70
Excessive cold	-	-	1	4	33	13	25	38
Hunger, thirst, exposure and neglect	13	-	1	9	23	16	30	46
Struck by falling object	5	2	4	3	5	12	7	19
Striking against or struck by object	4	2	3	3	7	10	9	19
Cutting or piercing instruments	2	1	-	8	4	10	5	15
Other and unspecified	10	4	11	13	36	31	43	74
TOTAL	74	16	65	67	144	185	181	366

The remaining 366 accidental deaths which occurred in and around the home during 1971 were attributed to other miscellaneous causes.

*A total of 529 people were accidentally drowned in England and Wales during 1971. Although only 85 of these accidents occurred at home, the majority of the remaining deaths were associated with everyday leisure activities.

†Excludes burns by heat from electrical appliances.

'OPEN VERDICT' DEATHS

In addition to the 6,245 fatal accidents, 475 people died in or around the home, but it was impossible to determine whether death was accidental or or purposely inflicted. Such cases are classified as 'open verdict' deaths.

As many as 358 of the 475 deaths were attributed to poisoning by various solids and liquids, and a further 28 deaths to gas poisoning. Twenty-five people died by drowning, and 21 people by hanging, strangulation or suffocation.

SECTION B

GENERAL PROVISION OF HEALTH AND WELFARE SERVICES

LABORATORY FACILITIES:

The Public Health Laboratory Service operating at the General Hospital, Northampton, was available for the diagnosis and analysis of specimens relative to infectious disease, and also for the bacteriological examination of water samples and was free of cost to the Authority. A helpful and efficient service was provided and we thank the laboratory staff for their constant co-operation.

AMBULANCE SERVICE:

Local ambulances under the control of the County Council are used for cases occurring in the District.

NURSING IN THE HOME, MIDWIVES AND HEALTH VISITOR SERVICES:

These are provided directly by the County Council, who have their nurses living in various parishes in the district.

CHILD WELFARE CENTRES AND CLINICS:

The County Council provide these services as follows:

Bozeat	-	Church Hall, 2 p.m. fourth Wednesday of the month.
Gt. Doddington	-	Parish Hall, 2 p.m. second Thursday of the month.
Earls Barton	-	Baptist School Rooms, 2 p.m. second and fourth Friday of the month.
Irchester	-	Parsons Hall, 2 p.m. first and third Friday of the month.
Wollaston	-	Village Hall, first and third Thursday of the month.

Pytchley, Isham, Harrowden and Orlingbury are served by the Mobile Clinic on the first Monday of the month and Overstone and Sywell on the first Wednesday of the month.

HOSPITAL ACCOMMODATION:

The Oxford Regional Hospital Board is responsible for these services which are as follows:-

General Hospitals	-	Northampton and Kettering.
Gynæcological	-	Wellingborough Hospital.
Acute Medical Cases, Skins and Children	-	Highfield Hospital, Wellingborough.
Chronic Sick, the Aged and Persons in Need of Care and Attention	-	Isebrook Hospital, Wellingborough, St. Mary's Hospital, Kettering.
Maternity	-	Isebrook Hospital, Wellingborough.
Tuberculosis	-	Rushden Hospital.
Infectious Diseases	-	Harborough Road Hospital, Northampton.
Orthopædic	-	Manfield Orthopædic Hospital, Northampton.

Out Patient facilities are available at the two General Hospitals and also at the Rushden Memorial Hospital, The Hayway, Rushden.

VENERAL DISEASES:

Out-patient Department, Kettering General Hospital. Tuesday of each week. Female 4.30 - 5.30 p.m. Male 5.30 - 6.30 p.m.

Northampton General Hospital:-

Males	Wednesday 2 - 3 p.m.	Friday 5 - 6.30 p.m.
Females	Monday 5.15 - 6.30 p.m.	Friday 2.15 - 3.30 p.m.

WELFARE OF THE AGED:

National Assistance Act, 1948, and Section 47, National Assistance (Amendment) Act, 1951.

Under this section the Council is responsible for the removal to suitable premises of persons needing care and attention. No action was necessary under this Act this year.

SERVICES FOR OLD PEOPLE:

The following provide services for old people:-

1. The National Health Service.
 - (a) General Practitioner Service;
 - (b) Hospital and Specialist Services.

2. The County Council

(a) The Heath Department

- (i) District Nurses;
- (ii) Health Visitors;
- (iii) Chiropody Services;
- (iv) Certain home equipment.

(b) The Social Services Department

From the 1st April, 1971, the Social Services Department was established in accordance with the requirements of the Local Authority Social Services Act, 1970. In Northamptonshire the department was formed by the amalgamation of the former Childrens' and Welfare Departments, together with several functions which were previously the responsibility of the Health Department including certain child health functions, care of the handicapped, and Mental Health and Home Help sections.

The following services are now provided for the elderly by this Department:-

- 1. Home Help Service - This is of inestimable value in the prevention of breakdown in the aged, and many are able to remain in their own homes who would otherwise have to be removed to institutions.
- 2. Residential Accommodation.
- 3. Holidays for the elderly.
- 4. Special services for the blind and deaf, and home fittings where necessary.

3. Department of Health and Social Security

Financial help where necessary.

4. The District Council

Homes for the aged, flats and in some cases flatlets with Warden supervision.

There are 67 two-bedroomed bungalows in the district which are allocated to the elderly.

5. Voluntary Organisation

These are many and services vary in different areas. They include holiday schemes in which old people are taken on seaside holidays in off-season times; the Darby and Joan Clubs; "Meals on Wheels" Service; the Home Visiting. The

Women's Royal Voluntary Service often undertakes many of the above duties, while in other areas local voluntary committees run the various organisations. The Rural Communities' Council, together with the Old People's Welfare Committee provide co-operation between the various services.

Your Medical Officer of Health, having a special interest in the welfare of the aged, and by virtue of her appointment both to the district and the County Council, and by her relationship with other medical colleagues, endeavours to fulfil the function of co-operation and co-ordination between these many agencies. Many cases of breakdown can be prevented by early application of these services.

The following villages have Old People's Clubs:-

Bozeat,	Gt. Doddington,	Mears Ashby,
Earls Barton,	Irchester,	Orlingbury and
Ecton,	Isham,	Wollaston.

SECTION C

SANITARY CIRCUMSTANCES OF THE DISTRICT

WATER SUPPLY

Water for the Wellingborough Rural District is supplied by two Boards, the Mid-Northamptonshire Water Board and the Higham Ferrers and Rushden Water Board. All parishes in the area have a piped and treated supply.

The following parishes receive a supply from the Mid-Northamptonshire Water Board:-

Isham, Hardwick, Lt. Harrowden, Gt. Harrowden, Orlingbury and Sywell.

The Higham Ferrers and Rushden Water Board supply:-

Bozeat, Wollaston, Easton Maudit, Gt. Doddington, Earls Barton, Ecton, Mears Ashby, Wilby, Grendon, Irchester, Lt. Irchester, Strixton and Newton Bromswold.

The sources of supply for the Mid-Northamptonshire Water Board are from reservoirs situated at Pitsford, Cransley, Thorpe Malsor and Hollowell. The gathering grounds cover about nineteen square miles and are mostly agricultural land with a certain amount of ironstone quarrying. The main reservoir, Pitsford, has a capacity of 4,000 million gallons and this reservoir is now supplemented by Grafam Water.

Treatment consists of the raw water flowing to a pumping station below the dam from where it is pumped to the treatment works. These works consist of a chemical block, reaction tanks, filters, filtered water tank and pumping station. The water is first softened and then passed through open rapid gravity filters and then to the filtered water tank for sterilisation by chlorine. Water thus treated is pumped to three trunk mains for distribution.

The sources of supply for the Higham Ferrers and Rushden Water Board are as follows:-

Sywell Reservoir - which has a capacity of approximately 236 million gallons. The catchment area is approximately 2,000 acres and the reservoir receives its supply from springs, two small brooks and surface rainwater. Treatment consists of filtration by means of slow sand filters, rapid gravity filtration and chlorination.

Hardwater Crossing, Wollaston - The source of supply is from wells sunk in the Nene river gravels. Treatment consists of mechanical filtration followed by chlorination.

Ditchford - This source is from gravels adjacent to the river at Ditchford. Collector ducts are laid in the gravels and the water extracted is brought to the treatment works. Treatment consists of rapid gravel filtration, partial softening, aeration and chlorination.

Further sources of supply are from springs and a gravel well at Earls Barton and springs at Grendon.

WATER CONSUMPTION

Consumption of water supplied by the Higham Ferrers and Rushden Water Board to the Wellingborough Rural Areas was as follows:-

Water used for domestic purposes ..	..	..	218,641,000 galls.
Therefore, average daily consumption ..	..	..	597,378 galls.
Water used for trade purposes ..	..	..	50,265,000 galls.
Therefore average daily consumption ..	..	..	137,336 galls.
Domestic purposes per head per day ..	..	..	37.1 galls.
Trade purposes per head per day ..	..	..	8.5 galls.
Total consumption per head per day ..	..	..	45.6 galls.

QUALITY OF WATER

Chemical analyses of water taken by the Higham Ferrers and Rushden Water Board during the year gave the following results:-

Chemical Analysis

Samples Contained	parts per 100,000
	Sywell (treated)
Ammoniacal Nitrogen	0.0060
Albuminoid Nitrogen	0.0076
Nitrous Nitrogen	absent
Nitric Nitrogen	0.10
Permanganate Figire	0.1023
Calcium	8.4
Magnesium	1.14
Chloride	4.0
Poisonous Metals	absent
Alkalinity	13.0
Total Hardness	17.8
Temporary Hardness	11.4
Permanent Hardness	6.4
Microscopic examination of Deposit	None
Bacteriological examination	C.O. absent

RAINFALL

	1972	1971	1970	1969	1968	1967	1966	1965	
Sywell	21.64	23.58	25.95	22.13	28.29	25.23	28.96	28.98	inches
Wollaston	20.24	20.95	25.07	20.12	26.88	21.71	26.31	25.56	inches

FLUORIDE CONTENT OF THE WATER SUPPLY

The water supply contains 0.24 parts of naturally occurring Fluoride per million parts of water.

SEWERAGE AND SEWAGE DISPOSAL

The Irchester Phase II Sewerage Scheme was completed in 1972 and the Council's Consulting Engineers were instructed to prepare for Irchester Phase III which will be the connection of the Irchester Foul Sewage System to the Wellingborough Regional Works. The Consulting Engineers were also instructed to prepare the scheme for the connection of Little Irchester Sewage to the Wellingborough Urban District sewers in the Embankment area. It is hoped that the scheme to connect six dwellings in Wollaston to the main sewerage system will be carried out in 1973. Work on the Mears Ashby/Earls Barton Scheme should commence early in 1973.

Planning approval has been obtained for a pumping station at the existing Sywell Sewage Disposal Works and eventually sewage from Sywell will be pumped to Mears Ashby and then to Earls Barton for treatment.

Provisional agreement was reached during the year with the Department of the Environment in connection with the Wollaston Regional Sewage Schemes and the Council's Consulting Engineers are now proceeding to prepare this scheme ready for formal submission to the Department.

During the year a 2,000 gallon sludge tanker was purchased enabling sludge from the Council's Sewage Disposal Works to be taken direct to Northampton County Borough Disposal Works and thus removing the task of digging out sewage from sludge drying beds.

Samples of sewage effluent were taken and the results are as follows:-

	<u>Satisfactory</u>	<u>Unsatisfactory</u>	<u>Total</u>
Bozeat	7	9	16
Earls Barton	11	5	16
Great Doddington	12	4	16
Grendon	6	10	16
Irchester	7	17	24
Little Irchester	1	-	1
Mears Ashby	3	-	3
Sywell	8	5	13
Wollaston, Main tank	12	44	56
Wollaston, Secondary tank	6	7	13

During the year 440 Septic Tanks were emptied as against 485 the previous year, 70 drains were cleansed, a reduction of 21 over the 1971 figures and 82 sewers were cleansed as compared with 95 previously.

SWIMMING POOLS

There is one public swimming pool in the area situated at Sywell. There are also swimming pools at the Secondary School of Wollaston, Grendon Hall and Earls Barton and Great Doddington County Primary Schools.

Results of samples taken for bacteriological examination during the year were as follows:-

	Number of <u>Samples</u>	<u>Very Satisfactory</u>	<u>Unsatisfactory</u>
Sywell	3	3	-
Wollaston School	2	2	-
Grendon Hall	1	1	-
Earls Barton School	-	-	-
Great Doddington School	1	1	-

DISINFECTION

Arrangements have been made over the years with the Rushden Urban District Council for the disinfection of articles of clothing or bedding associated with infectious diseases. It is understood however, that this machine is now no longer available, but as no use has been made of these facilities for some years and disinfection is carried out domestically, no difficulties are likely to arise.

PREVENTION OF DAMAGE BY PESTS ACT

170 domestic and other premises were treated during the year. Test baiting and treatment of sewers was carried out in the Autumn. It was not possible to carry out a treatment in the Spring owing to shortage of staff.

REFUSE COLLECTION AND DISPOSAL

The tip at Gipsy Lane, Irchester was closed in September and tipping commenced at the new site in Wollaston. The Pulverising Plant at this tip was officially opened in October, 1972. Draft heads of agreement have been exchanged with an adjoining Local Authority to use the tip and pulverising facilities for household refuse, and a local commercial firm are to use the tip for the disposal of plastic waste.

Due to the increase in private development in the District the Work Study

schedules were becoming stretched to their limits and it was necessary towards the end of the year to call in the Work Study Section of the County Council to remeasure the work load. Their report was received in December, 1972 and was to be discussed early in 1973.

The refuse collection was maintained throughout the year on the following days:-

Monday	-	Irchester; (Part) Great Doddington;
Tuesday	-	Grendon; Easton Maudit; Bozeat; Ecton; Sywell; Hardwick; Mears Ashby;
Wednesday	-	(Part) Great Doddington; Wilby; (Part) Earls Barton; (Part) Wollaston; Strixton;
Thursday	-	Little Irchester; (Part) Wollaston; Great Harrowden; Orlingbury; (Part) Little Harrowden; (Part) Earls Barton;
Friday	-	(Part) Little Harrowden; Isham; (Part) Earls Barton; Newton Bromswold.

PETROLEUM (CONSOLIDATION) ACT

The number of licences held in the District was 73.

CARAVAN SITES AND CONTROL OF DEVELOPMENT ACT, 1960

There are seven licensed residential sites in the area. There are also two holiday sites. One of these is situated partly in the Northampton Rural District. The other holiday site at Overstone Solarium has had its total of caravans increased to 1,000 and the licence conditions were modified by the Council during the year to allow for this and other matters. Generally, few difficulties were encountered with any of the sites.

THE DEPOSIT OF POISONOUS WASTE ACT, 1972

This act placed a general prohibition on the depositing of poisonous and other dangerous waste, made it a civil liability to do so, and laid the duty of those wishing to deposit to notify the responsible authorities prior to removal or deposition. Operators of commercial tips had also responsibility for notification and duties of local authorities were outlined in relation to enforcement of the act.

FUTURE PROBLEMS IN ENVIRONMENTAL HEALTH

While the foregoing is a report on the year 1972, at this historic time it is relevant to consider some of the problems which will face the reorganised department of environmental health in 1974.

The disposal of refuse, and the overall control of sewage works will

become the responsibility of County Councils and Water Authorities respectively. District Councils will retain their responsibility for sewerage, and collection of refuse. The need for co-operation between the authorities will be paramount. Likewise while the personal health services will be part of the National Health Service, environmental health together with the control of infectious diseases remains a District Council duty.

Successful environmental control can, however, never be achieved without consideration of the personal co-operation of the individuals living in the community. This is evident in its most pressing form in the need for population control. Unless achieved within the remaining years of the century the task of those endeavouring to maintain environmental health will be overwhelming. Already the environment is threatened by congestion on roads and countryside, noise, pollution of air, land, waterways and sea, housing shortages and the need for more services in many fields. The effect of this on the mental health of the people can be inferred by the increase in crime, delinquency, drug taking, alcoholism and child cruelty. The reorganised health services will have the responsibility for providing contraceptive services and plans to expand are already afoot. However in the acceptance by the population of these measures an enlightened health education service will have a vital part to play. Other aspects of health education will be shared by both authorities, Local Government accepting the need to provide instruction, particularly in safety at home, at work and on the road, and in food hygiene.

It is vital that the secure basis already achieved in the sanitary field is maintained, and the need for the prevention of further pollution, often from products innocently introduced for man's convenience, will be a major function. In rural areas, mass production methods in farming are creating further problems, particularly of smell and pollution and will ultimately require a system of national standards of control.

SECTION D

HOUSING

During the year 2 bungalows at Little Irchester and 8 flats at Wollaston were completed by the Council. A programme of capital works was agreed for a Warden Flatlet Scheme of 33 units at Irchester and a similar one at Little Harrowden. In addition a 23 bungalow unit, including a Warden's bungalow and community block, was agreed for Earls Barton and a scheme for 20 two-bedroomed flats at Little Irchester was also approved.

The modernisation of the six agricultural houses referred to in last year's report was completed and tenders were approved for the improvement of 8 houses each at Isham and Wollaston. It is hoped that work on the modernisation of 107 houses erected under the 1924 Act will commence early in 1973.

There were 308 persons on the Housing Waiting List at the end of the year and 41 houses became vacant or were built and were available for letting during the year.

The number on the Waiting List is high and owing to the housing situation in the area generally, is likely to be higher. The Council have approved a programme of new building to be carried out in 1973 and this is undoubtedly needed.

Nevertheless, in these circumstances further provision of local authority housing is required in the near future.

Private enterprise building continued with 170 houses being completed, a decrease of 180 over the previous year. At the end of 1972 there were 116 under construction, a decrease of 60 on 1971.

During the year forty Improvement Grants were approved, an increase of nine over the previous year. Four Standard Grants were made, the same number as in 1971. Seventeen Improvement Grants and five Standard Grants were completed in 1972.

POST-WAR SLUM CLEARANCE PROGRAMME

(1) Dwellings improved and made fit:

(a) Closing Orders determined	..	..	..	66
(b) Demolition Orders revoked	..	..	..	14
(c) Following undertakings being given by owners				14

94

(2) Dwellings demolished:

(a) Clearance Orders	..	..	..	..	95
(b) Demolition Orders	..	..	..	..	319
(c) Closing Orders	..	..	..	..	75
(d) M.O.H. Certificates	..	..	..	..	29
(e) Undertakings	..	..	..	..	3

(3) Dwellings still not demolished:

(a) Clearance Orders	..	..	..	..	-
(b) Demolition Orders	..	..	..	..	8
(c) Closing Orders -					
(i) approved for other uses			19		
(ii) not approved for other uses			37		
					<hr/>
					56
(d) Undertakings given by owners not to re-let for human habitation	..	..			11
					<hr/>

75

690

Houses dealt with during the year ended 31st December, 1972:

Closing Orders made	..	..	..	..	3
Demolition Orders made	..	..	..	..	1
Houses (subject to orders) made fit	..	..			3
Undertakings not to re-let	..	..	..		3

Houses demolished -

(a) Informally	..	..	..	1
(b) Demolition Orders	..	..		5
(c) Closing Orders	..	..		3
				<hr/>

9

SECTION E

INSPECTION AND SUPERVISION OF FOOD

The production and distribution of food has undergone major changes in the last quarter of the century. Technical advances, which have resulted in the manufacture of an increasing variety of food, with an improved keeping quality, quick transport, pure water, carefully controlled milk supply, and food hygiene legislation have all contributed to the raising of standards. However, many of the innovations have generated further problems of control and the increasing mobility of a rising population have added to, rather than lessened, the need for food hygiene supervision.

Many more premises are now vending food, some for immediate consumption. The almost universal use of refrigerator cabinets, while greatly improving hygiene, nevertheless requires careful stock rotation. There is an increase in the purchase of already cooked food for home consumption. The majority of the working population, including schoolchildren, take the mid-day meal at a canteen or cafe. Travel at home and abroad is general, the latter sometimes resulting in the importation of intestinal infections, not endemic in the local population, which in food handlers can cause grave concern. The rapid changes in personnel in the food industry needs supervision and education from employers and inspectors.

MILK SAMPLES

Twelve milk samples were taken during the year and the results were as follows:-

	No. of Samples	<u>Results:</u>	
		<u>Satisfactory</u>	<u>Unsatisfactory</u>
Pasteurised	10	10	-
Sterilised	1	1	-
U.H.T.	1	1	-

Routine sampling of milk is carried out by the authorities in whose areas pasteurisation plants are situated. Although there is no pasteurisation plant in the area it is advisable to take routine samples as the authority is responsible for the milk in the area.

ICE CREAM

Forty-eight premises are registered for the sale of ice cream. Forty-seven samples of ice cream were taken for examination and the results were as follows:-

No. of <u>Samples</u>	<u>Grade I</u>	<u>Grade II</u>	<u>Grade III</u>	<u>Grade IV</u>
47	41	6	-	-

These results are satisfactory.

FOOD PREMISES

During the year 117 inspections of food premises were carried out. It is only by such inspections that a high standard of hygiene can be maintained and this is one of the most important duties of the Public Health Inspectors.

Table No. 9 in Section H give a summary of the work carried out by the Inspectors during the year.

SLAUGHTERHOUSES

There are two slaughterhouses licensed in the area. Under the Meat Inspection Regulations, 1963, all carcasses are now required to be inspected and to be suitably marked when this is done. A charge is also made for this service. During the year 176 visits to slaughterhouses were made by the Public Health Inspectors. The following table gives details of the number of beasts slaughtered and the results of inspections:-

	Cattle excluding Cows	Cows	Calves	Sheep and Lambs	Pigs	Horses
Number killed (if known)	207	-	-	979	85	-
Number inspected	207	-	-	979	85	-
<u>All diseases except Tuberculosis and Cysticerci:</u>						
Whole carcasses condemned	-	-	-	-	-	-
Carcasses of which some part or organ was condemned	44	-	-	43	32	-
Percentage of the number inspected affected with disease other than cysticerci and T.B.	21.3	-	-	4.4	37.6	-
<u>Tuberculosis only:</u>						
Whole carcasses condemned	-	-	-	-	-	-
Carcasses of which some part or organ was condemned	-	-	-	-	-	-
Percentage of the number inspected affected with tuberculosis	-	-	-	-	-	-
<u>Cysticercus Bovis:</u>						
Carcasses of which some part or organ was condemned	4	-	-	-	-	-
Carcasses submitted to treatment by refrigeration	1	-	-	-	-	-
Generalised and totally condemned ..	-	-	-	-	-	-

The quantity of food condemned as unfit for human consumption was:

Meat	..	..	..	..	..	..	751 lb.
Tinned and other foods	..	..	..	..	..	..	54 lb.

SERVICE s UNDER THE FOOD AND DRUGS ACT, 1955

(a) Milk Supplies - Brucella Abortus

- | | | |
|-------|---|---|
| (i) | Number of samples of raw milk examined | - |
| (ii) | Number of positive samples found | - |
| (iii) | Action taken in respect of positive samples | - |

(b) The Liquid Egg (Pasteurisation) Regulations, 1963

- | | | |
|-------|---|---|
| (i) | Number of egg pasteurisation plants in the District | - |
| (ii) | Number of samples of liquidcegg submitted to the Alpha-Anylase test and their results | - |
| (iii) | Comments on the year's administration of these Regulations | - |

(c) Food Hygiene (General) Regulations, 1970

(i)	Number of food premises subject to Regulations	107
	Public Houses (Licensed Premises)	26
	Clubs	10
	Fish Frying	4
	Bakehouses	3
	Butchers	7
	Grocers	45
	Greengrocers	3
	Catering Premises	6
	Food Manufacturers	3
		<u>107</u>

(d) Poultry Inspection

Number of poultry processing plants in the district	1
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The following report has been received from Mr. F. J. Evans, Chief Inspector, Weights and Measures Department, and is acknowledged with thanks.

SAMPLES TAKEN IN WELLINGBOROUGH RURAL DISTRICT
IN THE TWELVE MONTHS ENDING 31st MARCH 1973

Milks	56	brought forward	96
Meat Products	14	Health Drink	1
Beer	2	Ice Cream Powder	1
Soft Drinks	6	Ice Cream	2
Cream	2	Cereal	1
Spirits	10	Custard Powder	1
Short Pastry Mix	1	Butter	1
Ready fresh dough	1	Margarine	2
Lemon pickle	1	Jam	1
Table jelly	1	Baby food	1
Prunes	1	Cooking Oil	1
Chocolate Drink	1	Mousse	3
carried forward	96	Fish Products	1
		TOTAL	112

REMARKS

Four of the samples taken in the Rural District during the period under review were found to be unsatisfactory by the Public Analyst.

A sample of lemon pickle was found to contain 85 parts per million of sulphur dioxide, the presence of which was not declared in the list of ingredients on the container. When the matter was taken up with the manufacturers they said that the product had been withdrawn from sale some considerable time prior to the sampling and they were surprised to find that any stocks remained at retail level. They gave an assurance that any other incorrectly marked jars would be recalled from sale immediately.

Following the receipt of a complaint from a member of the public that a kola flavoured drink had an unpleasant bitter taste, two samples were submitted for examination. The Analyst confirmed that saccharin was absent from the drink although its presence was declared in the list of ingredients. When the manufacturers were contacted and it was suggested that the only possible cause was an error on the part of a member of their staff in the preparation of the drink, which must have occurred in spite of their quality control procedures. They immediately withdrew all outstanding stocks and they were given a formal warning.

Although the description "cooking oil" was thought by the Analyst not to be sufficiently specific to comply with the labelling of Food Regulations, 1970, it was considered that the subsidiary description "a blend of vegetable oil" rendered the label a satisfactory one and the matter was not pursued with the packers.

Eleven samples of pasteurised milk supplied to schools in the Rural District were submitted to the Public Health Laboratory and were subjected to the methylene blue and phosphatase tests. All the samples were found to be satisfactory.

WEIGHTS AND MEASURES ACT 1963

Of the 3,737 articles which were checked for weight or measure during the year, 79 were found to be deficient. The errors were not serious enough to warrant the institution of legal proceedings and were dealt with by advice or caution to the traders concerned.

S E C T I O N F

PREVALENCE OF AND CONTROL OVER INFECTIOUS AND OTHER DISEASES

Health Services and Public Health Act, 1968

Public Health (Infectious Diseases) Regulations

Notification of food poisoning and infectious diseases

All provisions governing the notification of infectious disease and food poisoning are in Section 47 to 49 of the Health Services and Public Health Act, 1968, and the Public Health (Infectious Diseases) Regulations 1968.

The infectious diseases to be notified to the Medical Officer of Health are:-

Acute encephalitis	Opthalmia neonatorum
Acute meningitis	Paratyphoid Fever
Acute poliomyelitis	Plague
Anthrax	Relapsing fever
Cholera	Scarlet fever
Diphtheria	Smallpox
Dysentery	Tetanus
(amoebic or bacillary)	Tuberculosis
Infective jaundice	Typhoid Fever
Leprosy	Typhus
Leptospirosis	Whooping Cough
Malaria	Yellow Fever
Measles	

Since 1968 notification of the diseases listed below is no longer required:-

Acute influenzal pneumonia	Erysipelas
Acute primary pneumonia	Membranous croup
Acute rheumatism	Puerperal pyrexia

Responsibility for notifying a case or suspected case of food poisoning or infectious disease rests exclusively on the medical practitioner attending the patient unless he believes that another practitioner has already notified the case.

There was a decrease in the notification of infectious disease from 61 last year to 14 this year.

MEASLES

The incidence of measles notification decreased. There were no cases as compared with 55 in 1971. While measles is no longer a major cause of morbidity in Britain, it is an unpleasant illness and few reach adult life without having contracted it. In addition in the five years preceeding 1968 there were 467 deaths. An infection of such universality may result in complications, including neurological sequaelae and respiratory, eye and aural infections, and during an epidemic year as many as 8,000 hospital admissions may occur.

The regular biennial cycle of epidemics of measles failed to occur in the 1968-1969 winter and again in the winter of 1969-1970 there was no national epidemic, due probably to the programme of immunisation which began in 1968. The suspension in March 1969 of a certain batch of vaccine led to a shortage and the rate of immunisation has been less than sufficient to prevent the number of susceptible children increasing with the new births each year. It was evident by the middle of 1970 that the incidence of measles would be high as notifications markedly increased and continued throughout the year. By mid-1970 sufficient supplies of vaccine were available and vaccination was resumed, however during late 1970 and throughout 1971 there was a significant rise of measles notifications nationally and a campaign, initiated by the Chief Medical Officer of the Department of Health, to promote further measles vaccination was successful and there was a considerable increase in the numbers of children vaccinated.

During 1972 the figures continued to rise and in the county 5,752 children were vaccinated between the ages of one and seven years. 72% of children born between 1st January 1968 and December 1971 were vaccinated. It is to be hoped that a sufficient number of susceptibles will now be vaccinated and that 1971 will be the last year when a high incidence of measles is recorded.

RUBELLA

Rubella vaccination became available in November 1970, and this was offered to all girls in their 14th year of life i.e. aged 13. Following the increased availability of the vaccines this age limit has now been lowered to include 11 and 12 year old girls.

Vaccination is also offered to female teachers of child bearing age because of the likelihood of their coming into contact with the infection in school. In the county 279 took up the offer, but only 31 had negative haemagglutination inhibition titres, who were vaccinated. Female members of the health department staff were offered similar facilities and 18 of 47 needed protection.

WHOOPING COUGH (PERTUSSIS)

There were no cases of whooping cough notified during the year, compared with three cases in 1971. This is another condition which is becoming largely more benign, but in some cases can be distressing and in infancy, a serious illness. Protection to this disease is often by triple vaccination, together with tetanus and diphtheria.

The County Council are participating in a survey on the efficacy of pertussis vaccination with the Public Health Laboratory Service. Details of notifications together with (where possible) the vaccinal state of the child are provided. The surveillance will include an analysis of the attack rate in vaccinated and unvaccinated children in areas with computer facilities.

SCARLET FEVER

Once again, as in 1971, no cases were notified. This disease continues in its mild phase. Its principal interest is that it gives a rough indication of the amount of streptococcal infection in the community.

SMALLPOX

There were no cases. It has recently been recommended by the Department of Health and Social Security that vaccination against smallpox need no longer be carried out as a routine procedure in early childhood as the risk of exposure to infection is far less likely than at any previous time since the disease was first recorded in this country.

It is however, emphasised that all travellers to and from areas of the world where smallpox is endemic or countries where eradication programmes are in progress, and health service staff who come into contact with patients, should be offered vaccination and re-vaccination.

DIPHTHERIA

There have been no cases of diphtheria in Northamptonshire since 1956. There is therefore, with each successive year of freedom from infection, a diminishing recollection of the dangers of this illness. Mothers without knowledge of the disease feel a false security and may not have their children immunised. That this is a dangerous situation cannot be too strongly stressed, as it is only by keeping up the numbers of children immunised that the disease can be kept in check. It is the duty of all parents to have their children immunised, and if they fail to do so, they neglect their welfare.

POLIOMYELITIS

Once again there have been no cases, and this freedom can be ascribed to immunisation as the decline in incidence has occurred concurrently with vaccination. The oral Sabin vaccine is now used which gives a longer lasting immunity than the Salk or injected variety. A drink of syrup or a lump of sugar is also much more acceptable to the young patients than the previous needle prick.

DYSENTERY

There were no cases of dysentery notified.

FOOD POISONING

The condition is usually caused by one of the Salmonella organisms, the commonest being the typhimurium strain or paratyphoid A or B. The Staphylococcus gaining an entry to food from an infected spot or boil on the hands, arm or face of a food handler may also cause a severe form of food poisoning. Occasionally food may be chemically contaminated. Typhoid fever is a rare condition, but like the other salmonellae may gain entry into food by faulty hygiene of food handlers. The sources of infection can be numerous, uncooked contaminated (often imported) meat or poultry being today some of the commonest. Travel abroad resulting in the importation of infections is another source and can cause problems of hygiene in food handlers.

14 cases were notified.

The first case occurred in February in a six months old baby. He was admitted to a general hospital with a chest infection and later transferred to an isolation hospital where he remained until the end of April. No other members of the family were infected and it was early June before three consecutive negative samples were received. The organism was typed as Salmonella Infantis. The source of infection was not identified.

The other 13 cases notified were in July and were amongst pupils and staff of Grendon Primary School. There were altogether 20 cases in the outbreak, the remaining seven living in a neighbouring district.

On July 7th 1972, a boy of seven years (a pupil from Grendon Primary School) admitted to the Northampton General Hospital with abdominal symptoms was diagnosed as suffering from a Salmonella infection. On investigation it was found that since July 2nd a number of children and staff had been suffering from gastro-intestinal upsets at the school.

The school is a small village primary (number of pupils 56) of

Victorian construction, which has been modernised and with adequate internal hygiene arrangements. The school dinners are cooked at the John Lea Secondary School, Wellingborough, some 8 miles distant, and are transported in heated containers, which are delivered approximately half an hour before being served, the food remaining in the containers during this period.

All pupils, school meals and teaching staff were stool-sampled and it was found that a number of individuals who had intestinal symptoms, even after repeated sampling, were negative. It was finally concluded that two infections had occurred concurrently as symptoms differed in those with negative stools from those who were positive to Salmonella. These findings confused the investigation at the outset. However as the inquiry proceeded it became clear that all the Salmonella infected individuals, both pupils and staff had partaken of a school dinner on June 30th, but were only a fraction of the total number who had eaten the dinner. The meal provided was meat pie which when made up was placed in separate rectangular containers or trays. The trays were packed and transported, arriving at the school at 11.35 where they remained until they were opened and cut up before serving. They were in the warm room for about 10-15 minutes, each container being allocated to a separate table. Those infected had all eaten pie from a single container. A full investigation was made of the school meals staff at Wellingborough, and of those who took any part in transporting the meal. None was found to be positive. There was no evidence either of infection from any other school receiving dinners cooked at John Lea School. It was finally concluded that the infection had been introduced to a single tray of meat pie after preparation and cooking and extensive investigations failed to ascertain the source of this infection. The school meals organiser had introduced stringent measures to prevent any possibility of recurrence of the incident.

The infection occurred in the school one week before the summer holiday and as the headmaster and dining room staff were affected the school was closed a week early. Prior to returning after the summer holiday, all children from the school together with the family contacts of those infected were re-tested, and no infected child returned until three consecutive negative samples had been received. Within a week of the new term beginning all children were clear and back at school.

All those infected were carefully instructed in details of hygiene to prevent any spread of infection, and this was successful as there were no further cases apart from those originally infected at school.

The headmaster of the school was particularly helpful in the investigation and it was he who related the cause to a single tray of meat pie.

Information was received that Salmonella Typhimurium phage type 26 is sometimes related to terrapins. No such association was found in this instance.

No. of pupils affected was:-

<u>Girls</u>	<u>Boys</u>	<u>Total</u>
9	7	16

No. of staff affected:-

Headmaster	1
School Meals Supervisor	1
Dining Room Assistant	1

Plus one pre-school child, daughter of Dining Room Assistant,
who also ate the meal 1

TOTAL	<u>20</u>
-------	-----------

RESPIRATORY INFECTIONS AND INFLUENZA

Four deaths are recorded this year from pneumonia, 3 from bronchitis and four from influenza.

Other respiratory infections are now seldom a cause of death, except as a terminal event, but remain a considerable cause of ill-health. These are still the highest cause of loss of working hours and bronchitis, nasal catarrh and sinus infections are still a cause of much disability.

INFECTIVE JAUNDICE

No cases were notified compared with one in 1971. The Minister of Health gave sanction that this disease should be made locally notifiable as from 1st July, 1962. By arrangement with other local authorities this also became operative in Northamptonshire. Under the Health Services and Public Health Act, 1968, infective jaundice became nationally notifiable.

Acute infective hepatitis is a disease caused by a virus which attacks the liver and causes jaundice. It is mainly an infection of young people, of faecal-oral spread, with an incubation period of 15-50 days. The incriminative routes of infection are from food-handlers, water and children to their mothers. The virus is present in faeces, 16 days before jaundice and up to 8 days afterwards. Serum hepatitis, which is another form of infective hepatitis, has a longer incubation period of 50-160 days and affects mainly adults and can be spread by blood transfusion and inefficiently sterilised equipment used by doctors, dentists and nurses, drug addicts and in the various tattooing processes. The clinical groups of these two groups of hepatitis are indistinguishable. There is no specific treatment and jaundiced adults may be away from work from six weeks to two months and sometimes may not feel really fit for a year. Quarantine measures are of little value and patients can be treated at home or in hospital, provided that adequate

hand-washing techniques are practised, and concurrent disinfection of excreta. Serum hepatitis could be virtually abolished if disposable equipment were generally introduced. In the County, disposable equipment is used by the County Health Department for all procedures involving immunisation. Gamma Globulin is of great value for the protection of close contacts and pregnant women during epidemics.

TUBERCULOSIS

Two names were added to the Register during the year, however one of these patients died two weeks after notification. Four names were removed from the Register - two being now healed, and two moving out of the area. The following table shows the number of known cases of Tuberculosis in the District as at 31st December, 1972:-

	<u>Males</u>	<u>Females</u>	<u>Total</u>
Respiratory	15	12	27
Non-respiratory	2	10	12
	<u> </u>	<u> </u>	<u> </u>
TOTALS:	17	22	39
	<u> </u>	<u> </u>	<u> </u>

S E C T I O N G

FACTORIES ACT, 1961

There are 81 factories in the Rural District. 28 inspections were made. Table No. 10 in Section H gives further information.

The number of Outworkers on the August list was 92. No action was necessary in respect of Sections 133 and 134 which concerned homework.

OFFICES, SHOPS & RAILWAY PREMISES ACT, 1963

Class of premises	Premises newly registered during the year	Total number of premises at end of year	Number of general inspections during the year
Offices	1	5	1
Retail Shops	1	25	5
Wholesale shops, warehouses	-	7	-
Catering establishments, canteens	-	2	-
Fuel storage depots	-	1	-
TOTALS	2	40	6

Number of visits of all kinds by Inspectors to registered premises - 13

ANALYSIS OF PERSONS EMPLOYED IN REGISTERED PREMISES BY WORKPLACE

Class of workplace	Number of persons employed
Offices	28
Retail shops	128
Wholesale departments, warehouses	100
Catering establishments	27
Canteens	-
Fuel storage depots	2
TOTAL	285
TOTAL MALES	169
TOTAL FEMALES	116

S E C T I O N H

DEATHS FROM SELECTED CAUSES

Table No. 1

Year	Non-Pulmonary Tuberculosis		Pulmonary Tuberculosis		Cancer		Diseases of Heart and Blood Vessels		Bronchitis Pneumonia and other Respiratory Diseases	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
1946	2	.15	5	.39	22	1.75	61	4.86	20	1.59
1947	2	.16	3	.23	25	1.96	93	7.31	17	1.33
1948	-	-	5	.39	19	1.48	87	6.81	13	1.01
1949	-	-	3	.23	16	1.23	89	6.86	22	1.69
1950	2	.15	4	.30	29	2.18	89	6.71	18	1.35
1951	-	-	3	.23	22	1.69	75	5.76	29	2.23
1952	3	.23	3	.23	24	1.69	101	7.76	9	0.69
1953	-	-	-	-	15	1.04	75	5.21	9	0.62
1954	-	-	-	-	35	2.45	68	4.76	12	0.84
1955	-	-	1	.07	32	2.27	85	6.04	9	0.63
1956	1.	.07	-	-	36	2.64	97	7.13	8	0.58
1957	-	-	-	-	33	2.42	86	6.32	6	0.44
1958	-	-	3	.21	40	2.85	87	6.21	6	0.42
1959	-	-	1	.07	26	1.83	92	6.43	13	0.93
1960	-	-	1	.06	18	1.21	90	6.07	17	1.14
1961	-	-	1	.07	19	1.39	72	5.27	19	1.39
1962	-	-	-	-	25	1.82	66	4.80	18	1.30
1963	-	-	-	-	29	2.09	82	5.92	26	1.87
1964	-	-	-	-	28	2.08	81	5.82	12	0.86
1965	-	-	1	.07	34	2.40	68	4.80	22	1.55
1966	-	-	-	-	36	2.50	82	5.70	17	1.18
1967	-	-	-	-	32	2.16	72	4.87	13	0.87
1968	-	-	-	-	36	2.29	93	5.92	21	1.33
1969	-	-	1	.06	42	2.56	93	5.68	21	1.28
1970	-	-	1	.05	49	2.86	107	6.25	27	1.58
1971	-	-	1	.05	31	1.65	98	5.23	25	1.38
1972	-	-	1	.05	39	1.99	89	4.55	11	0.56

COMPARISON OF STILLBIRTHS, ILLEGITIMATE BIRTHS
AND MASCULINITY OF BIRTH

Table No. 2

Year	Stillbirths per 1,000		Illegitimate Births per 1,000 live births	Male births per 1,000 live female births
	Population of all ages	Total Births (Live and Still)		
1946	.39	22.32	105.02	1,027
1947	.39	22.02	58.55	1,055
1948	.54	30.56	72.07	947
1949	.38	23.80	51.28	1,029
1950	.15	10.81	32.78	1,033
1951	.69	48.38	39.54	1,082
1952	.15	10.36	47.12	1,122
1953	.34	25.51	36.64	989
1954	.14	10.86	65.93	1,246
1955	.49	37.03	71.42	1,166
1956	.22	15.38	31.25	828
1957	.29	23.39	35.92	1,287
1958	.50	37.43	16.66	1,090
1959	.14	10.15	20.51	875
1960	.26	17.85	45.45	1,136
1961	.36	22.52	55.29	990
1962	.07	4.10	41.66	967
1963	.14	9.25	74.67	1,229
1964	.14	8.03	56.68	1,075
1965	.56	29.00	48.98	1,205
1966	.14	7.66	46.33	773
1967	.47	24.39	46.43	1,022
1968	.13	6.90	45.13	972
1969	.12	6.23	40.75	1,278
1970	.35	16.00	36.96	1,185
1971	.32	15.00	47.73	1,215
1972	.10	5.00	27.13	1,083

VITAL STATISTICS FOR 1972 AND PREVIOUS YEARS

Table No. 3

Year	Estimated Population	Births		Deaths			
				Under 1 year		All ages	
		No.	Rate per 1,000 pop.	No.	Rate per 1,000 Live Births	No.	Rate per 1,000 pop.
1946	12,530	219	17.47	15	68.49	152	12.13
1947	12,720	222	17.45	7	31.49	189	14.85
1948	12,760	222	17.39	13	58.55	153	11.99
1949	12,960	205	15.81	8	39.02	172	13.27
1950	13,250	183	13.81	7	38.25	170	12.83
1951	13,000	177	13.61	7	39.54	186	14.30
1952	13,000	191	14.69	3	15.18	174	13.33
1953	14,370	191	13.29	6	31.45	128	8.90
1954	14,270	182	12.76	2	10.98	144	10.09
1955	14,070	182	12.93	6	32.96	153	10.87
1956	13,600	192	14.11	4	20.83	176	12.94
1957	13,590	167	12.28	2	11.97	156	11.47
1958	14,000	180	12.85	2	11.11	161	11.50
1959	14,180	195	13.75	4	20.51	160	11.23
1960	14,820	220	14.84	7	31.81	161	10.86
1961	13,660	217	15.38	4	18.43	137	10.02
1962	13,770	240	17.42	4	16.66	139	10.09
1963	13,840	214	15.49	6	28.03	159	11.48
1964	13,950	247	17.69	3	12.15	139	9.99
1965	14,140	247	17.68	3	12.15	154	10.89
1966	14,380	259	17.32	5	19.30	173	12.03
1967	14,780	280	18.9	4	13.94	142	9.60
1968	15,720	288	18.32	6	20.83	182	11.58
1969	16,350	319	19.51	4	12.53	188	11.49
1970	17,130	378	22.10	4	11.00	212	12.40
1971	18,710	398	21.30	11	28.00	193	10.30
1972	19,570	398	20.30	8	20.00	167	8.50

TUBERCULOSIS

New Cases and Mortality During 1972

Table No. 4

Age Periods	New Cases				Deaths			
	Respiratory		Non-Respiratory		Respiratory		None Respiratory	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 1	-	-	-	-	-	-	-	-
1 - 4	-	-	-	-	-	-	-	-
5 - 14	-	-	-	-	-	-	-	-
15 - 24	-	-	-	-	-	-	-	-
25 - 34	-	-	-	-	-	-	-	-
35 - 44	1	-	-	-	-	-	-	-
45 - 54	-	-	-	-	-	-	-	-
55 - 64	-	-	1*	-	-	-	1	-
65+	-	-	-	-	-	-	-	-
TOTALS	1	-	1	-	-	-	1	-

* Died two weeks later.

MONTHLY INCIDENCE OF NOTIFIABLE DISEASES

(Other than Tuberculosis) 1972

Table No. 5

Disease	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
Scarlet Fever	-	-	-	-	-	-	-	-	-	-	-	-	-
Meningitis	-	-	-	-	-	-	-	-	-	-	-	-	-
Measles	-	-	-	-	-	-	-	-	-	-	-	-	-
Whooping Cough	-	-	-	-	-	-	-	-	-	-	-	-	-
Diphtheria	-	-	-	-	-	-	-	-	-	-	-	-	-
Dysentery	-	-	-	-	-	-	-	-	-	-	-	-	-
Food Poisoning	-	1	-	-	-	-	13	-	-	-	-	-	14
Poliomyelitis	-	-	-	-	-	-	-	-	-	-	-	-	-
Infective Hepatitis	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	-	1	-	-	-	-	13	-	-	-	-	-	14

AGE INCIDENCE OF NOTIFIABLE DISEASES

(Other than Tuberculosis) 1972

Table No. 6

Disease	0+	1+	2+	3+	4+	5+	10+	15+	20+	35+	45+	65+	All ages	Removed to Hospital	Deaths
Scarlet Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Meningitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Measles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Whooping Cough	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Diphtheria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dysentery	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Food Poisoning	2	-	-	-	1	6	2	-	2	1	-	-	14	-	-
Ophthalmia Neonatorum	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Typhoid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Para-typhoid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Polio-myelitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Infective Hepatitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	2	-	-	-	1	6	2	-	2	1	-	-	14	-	-

INCIDENCE OF NOTIFIABLE DISEASES

(other than Tuberculosis)

IN INDIVIDUAL PARISHES, 1972

Table No. 7

	Scarlet Fever	Meningitis	Measles	Whooping Cough	Tetanus	Leptospirosis	Diphtheria	Poliomyelitis	Food Poisoning	Dysentery	Infective Hepatitis	Para-typhoid	Malaria	TOTAL
Bozeat	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Doddington, Great	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Earls Barton	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Easton Maudit	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ecton	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Grendon	-	-	-	-	-	-	-	-	12	-	-	-	-	12
Hardwick	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Harrowden, Great	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Harrowden, Little	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Irchester	-	-	-	-	-	-	-	-	2	-	-	-	-	2
Irchester, Little	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Isham	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mears Ashby	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Newton Bromswold	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Orlingbury	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Strixton	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sywell	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wilby	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wollaston	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTALS	-	-	-	-	-	-	-	-	14	-	-	-	-	14

HOUSING PROGRAMME UP TO 31ST DECEMBER, 1971

Table No. 8

1.	Number of houses proposed to be erected as approved by the Ministry of Housing and Local Government to date							1,044	
2.	(a) Number of sites concerning which layout plans and house plans have been approved by the Ministry of Housing and Local Government							58	
3.	Superficial area plans approved, determined in accordance with paragraph 4 of the Standards of New Houses adopted by The Joint Committee:								
	(a)	Non-parlour types	2 bedrooms	X type	square feet		846		
			2	"	R	"	868		
			2	"	I	"	872		
			3	"	M	"	916		
			3	"	N	"	952		
			3	"	O	"	965		
			3	"	P	"	972		
			3	"	J	"	946		
			3	"	H	"	937		
			3	"	G	"	914		
			3	"	F	"	912		
			3	"	K	"	850		
			3	"	L	"	927		
			3	"	B	"	900		
		Convertible 3 to	4	"	V	"	903		
	(b)	Parlour type	3 bedrooms	D type	square feet		800		
			Duplex	E	"	"	840		
	(c)	Bungalow	2 bedrooms	Q	"	"	745		
			2	"	T	"	635		
			2	"	Y	"	616		
		1 bedroom	2 persons	U	"	"	564		
		1	"	1	"	S	"	349	
		1	"	1	"	Z	"	384	
		1	"	2	"	PM7	"	569	
	(d)	Flats	2	"	4	"	A	"	718
			1	"	2	"	PM3	"	548
			2	"	3	"	PM6	"	785
4.	Number of houses for which tenders have been invited							257	
5.	Number of houses the erection of which have begun							1,044	
	Number of houses approved but not erected							--	

SUMMARY OF SANITARY INSPECTIONS, ETC.

Table No. 9

Number of visits and inspections	..	..	..	..	..	..	..	1,581
Slaughterhouses on Register	..	..	..	..	..	..	..	2
Number of Slaughtermen licensed	..	..	..	..	..	..	..	7
Visits to slaughterhouses	..	..	..	..	..	..	..	176
Visits to Butcher's shops	..	..	..	..	..	..	..	9
Number of Bakehouses	..	..	..	..	..	..	..	4
Visits to Bakehouses	..	..	..	..	..	..	..	4
Food condemned as unfit for human consumption	..	..	..	..	..	..	..	805 lb.
Premises licensed to sell Ice Cream	..	..	..	..	..	..	..	48
Smoke and Dust Nuisance	..	..	..	..	..	..	..	14
Premises infested with flies, ants, wasps etc.	..	..	..	..	..	..	..	72
Animals kept as to be a nuisance	..	..	..	..	..	..	..	3
Inspection of Food Premises	..	..	..	..	..	..	..	117
Housing Act Inspections	..	..	..	..	..	..	..	203
Licences issued under Milk (Special Designation) Regulations 1963	..	..	..	..	..	..	..	7
Offensive Trade	..	..	..	..	..	..	..	74
Infectious Diseases	..	..	..	..	..	..	..	144
Samples of water taken	..	..	..	..	..	..	..	7
Caravan Sites Act, 1960	..	..	..	..	..	..	..	18
Noise Abatement Act	..	..	..	..	..	..	..	28
H.C.N. Fumigation Regulations	..	..	..	..	..	..	..	-
Animal Boarding Establishments	..	..	..	..	..	..	..	3
Offices, Shops and Railway Premises Act, 1963	..	..	..	..	..	..	..	13
Filthy and Verminous Premises	..	..	..	..	..	..	..	6
Imported Food	..	..	..	..	..	..	..	39
Civic Amenities Act	..	..	..	..	..	..	..	27
Petroleum (Consolidation) Act	..	..	..	..	..	..	..	19
Drainage and Sewerage	..	..	..	..	..	..	..	47
Nuisances Investigated	..	..	..	..	..	..	..	58
Visits to Council Houses	..	..	..	..	..	..	..	202

— 00000 —

Table No. 10

Prescribed particulars on the administration of the Factories Act, 1961.

Section 153(1), for the year 1972

PART I OF THE ACT

1. INSPECTIONS for the purpose of provisions as to health (including inspections made by Public Health Inspectors).

Premises	Number on Register	Number of		Occupiers Prosecuted
		Inspections	Written Notices	
(1) Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by Local Authorities	1	1	0	0
(2) Factories not included in (1) in which S.7 is enforced by the Local Authority	80	27	8	0
(3) Other premises in which S.7 is enforced by the Local Authority (excluding outworkers' premises)	0	0	0	0
TOTAL	81	28	8	0

Table No. 10

- continued.

2. Cases in which DEFECTS were found.

Particulars	No. of cases in which defects were found				No. of cases in which prosecutions were instituted
	Found	Remedied	Referred to H. M. Inspector	by H. M. Inspector	
Want of cleanliness (s.1)	-	-	-	-	-
Overcrowding (s.2)	-	-	-	-	-
Unreasonable temperature (s.3)	-	-	-	-	-
Inadequate ventilation (s.4)	-	-	-	-	-
Ineffective drainage of floors (s.6)	-	-	-	-	-
Sanitary conveniences (s.7)	-	-	-	-	-
(a) Insufficient	-	-	-	-	-
(b) Unsuitable or defective	8	-	-	-	-
(c) Not separate for sexes	-	-	-	-	-
Other offences against the Act (not including offences relating to Outwork)	-	-	-	-	-
TOTAL	8	-	-	-	-

PART VIII OF THE ACT - OUTWORK

Table No. 10

- continued.

Nature of Work	SECTION 133			SECTION 134		
	No. of out-workers in August list required by Sect. 110(1)(c)	No. of cases of default in sending lists to the Council	No. of prosecutions for failure to supply lists	No. of instances of work in unwholesome premises	Notices served	Prosecutions
Wearing apparel:						
Making, etc.	92	-	-	-	-	-
Cleaning and Washing	-	-	-	-	-	-
Curtains and furniture hangings	-	-	-	-	-	-
Furniture and Upholstery	-	-	-	-	-	-
Lampshades	-	-	-	-	-	-
Carding, etc. of Buttons etc.	-	-	-	-	-	-
The making of boxes or parts thereof made wholly or partially of paper	-	-	-	-	-	-
Household Linen	-	-	-	-	-	-
TOTAL	92	-	-	-	-	-

A P P E N D I X

THE ROLE OF THE COMMUNITY PHYSICIAN IN THE REORGANISED

NATIONAL HEALTH SERVICE

Community medicine is that function of medicine which concerns itself with populations, rather than with single individuals. A community is all the people living within a defined geographical area whether at home, in school, at work, or in hospital. There has been some semantic misinterpretation implying that community was separate from hospital.

In the introduction to the Standing Orders of the Faculty of Community Medicine, Royal College of Physicians (1972) the specialty is defined as "that branch of Medicine which deals with populations or groups rather than with individual patients. In the context of a national system of medical care, it, therefore, comprises those doctors who try to measure accurately the needs of the population both sick and well. It requires to bring to this study special knowledge of the principles of epidemiology, of the organisation and evaluation of medical care systems, of the medical aspects of the administration of health services, and of the techniques of health education and rehabilitation which are comprised within the field of social and preventive medicine. Community Medicine thus brings together within the one discipline those who are presently engaged in the practice of public health, in the administration of the health services whether in hospital, local authority, or central government, in relevant research, and those responsible for undergraduate and postgraduate education in the University departments of social medicine."

The reorganised National Health Service, including the new discipline of community medicine, will end the century of practice of public health as a responsibility of local government authorities.* The era was one of major progress in eliminating the gross environmental abuses to human health, and developing the personal preventive services in school health, maternal and child health. The National Health Service Act, 1948, with its deliberate tripartite structure, excluded these services allowing them to remain the responsibility of the local authorities. This decision was a compromise and permitted central government to concentrate on developing therapeutic services, particularly the building up of hospital provisions, which were already crumbling and in some areas non-existent.

*(The Local Government Board was created in 1871; in 1874 the office of a medical officer of health was created; and the first D.P.H. exam was held in Cambridge in 1875).

The achievement of this latter objective has been notable. After twenty years the sharp edges of the tripartite system were becoming blurred, and the need for reorganisation was increasingly evident. These changes, many of which evolved as a result of initiative from the public health service, are now recognised and given impetus by legislation. As in 1948, the 1974 reorganisation will result in a similar (and deliberate) amalgam of compromise and concessions. While the personal health services will cease to be the responsibility of the local authorities, school and environmental health will remain with them, and arrangements will be necessary to maintain co-operation with the social services which retain many functions complementary to health.

Reorganisation of health services are timed to coincide with and relate geographically to the boundaries of local government.

THE 1974 REORGANISED STRUCTURE

Central government will maintain overall control with strengthened regional divisions at the Department of Health and Social Security. Finance will be centrally determined, and priorities, national standards, and objectives will be decided and resources allocated (unlike local government who first consider needs) to regions, which will largely follow, geographically, the present 14 Regional Hospital Boards. Within the regions there will be 90 Area Health Authorities co-terminus with the county and metropolitan councils of the reorganised local government. General practitioners will retain their independent status, executive councils being replaced by family practitioner committees (a part of the area structure). Central control is envisaged as tight, and regions "will co-ordinate activity and monitor performances at area to ensure that national and regional objectives are achieved."

While the structure of the reorganised health services is not considered in detail it is useful to sketch the broad framework in which community physicians will function. Each Regional Health Authority will have a Chairman (nominated by the Secretary of State) and a committee selected for their managerial skills. At officer level, the regional team of officers will consist of a medical officer, nurse, administrator and treasurer, each with their staffs. The regional authority will be responsible for the general planning of all health services, allocation of finance at region and area, and for a number of specialist services including neuro, plastic and thoracic surgery, radiotherapy and blood transfusion, together with undergraduate teaching.

There will be 90 Area Health Authorities, each having a Chairman (nominated by the Secretary of State) and fourteen members. Areas will contain from one to five (or more) district general hospitals within their boundaries and have overall responsibility for providing all health services for the population. As stated the area will relate geographically to the boundary of the reorganised local authority. Exact co-terminosity cannot always be

achieved and there will be overlap areas the servicing of which is a necessary part of forward planning. The area will also be responsible for the setting up of Community Health Councils, which will serve the constituent districts and who will represent the consumer use of the National Health Service.

The area medical officer will be a member of the area team of officers, consisting of nurse, administrator and treasurer, and will have a staff of community physicians responsible for various administrative and preventive medical functions.

At both region and area Joint Liaison Committees have been established for the purpose of co-ordinating the preparatory work required prior to re-organisation, and with the responsibility of collating information, defining districts and making preliminary assessment of matters requiring decision by the shadow authorities.

GENERAL ACTIVITIES OF THE COMMUNITY PHYSICIAN

Community physicians will function within these administrative units, the regional and area medical officer with their individual teams of community medicine specialists, while at district (the real operational level) there will be a district community physician, who will also be a member of a district team of officers, which will include clinicians from general practice and hospitals.

At all levels community physicians will be responsible for a wide spectrum of activities which will include planning, particularly at area and regional level; the measurement and evaluation of health programmes; the development of information systems which will include record linkage, the use of statistics, computers, morbidity and mortality indices. Planning will require national co-ordination between hospital and community and here assessment of priorities will be vital. In the field of preventive medicine, child health (including the school health service), health education, identification of vulnerable groups, screening, and a grasp of the effects of advances in medical knowledge will all have a part, and will need skills to anticipate and deploy resources to achieve success.

Community physicians will be members of teams. This function will require new skills and success will depend on being able to convince colleagues, by the careful building up of information systems based on data, of population needs, the evaluation of existing services and the assessment of options, to accept policies and achieve agreement, then setting out successfully to implement those policies. The term 'accountability upwards and delegation downwards' if it is to work successfully will require full understanding and co-operation between officers at all levels.

THE COMMUNITY PHYSICIAN AT DISTRICT LEVEL

It is at this level that advice on environmental health to the local authorities will be required, and either the district community physician, or more likely, a designated specialist in community medicine, will act as the 'proper officer' to advise district councils on environmental health.

The health service district will be that area served by the district general hospital, involving populations varying in size from 150,000 to 300,000. Services cannot be organised on a strict geographical basis as choice of specialist will remain the prerogative of the general practitioners. Patient flows may vary with specialty. The defined boundaries enjoyed by local authorities will not therefore be applicable for health services and flexible overlap arrangements will be required.

The basic unit of the reorganised health service is the district in which primary care services supplied by family practitioners, either working in group practices, or in health centres, will be supported by the secondary specialist services based in the district general hospital. The community physician at this level will have many functions; as a member of the district medical team (the only team on which clinicians will serve); as co-ordinator of health care teams for children, the elderly, maternity, mental and mentally handicapped services, together with any other ad hoc team locally organised. He may also act as adviser to the local district councils on environmental health. He will be required to provide information and advice on all aspects of health needs and on the best deployment of resources to meet those needs.

The district will be the optimum level at which to plan and provide a substantially comprehensive service, in which the community physician will have a vital role in organising operational policies and developing district plans.

COLLABORATION WITH LOCAL AUTHORITIES

Collaboration Committees are to be established which will include members from both local authorities and the National Health Service, with the responsibility to initiate and maintain the strongest links between the two services. Medical advice will be provided by community physicians and their staffs. Thus a major function of the community physician will be in his role as link between the local authorities and reorganised National Health Service. His success in maintaining the relationship with them will be a major factor in sustaining domiciliary services. The social services departments will retain their responsibility for the home help services, for mental health, the elderly, care of children, the handicapped and other services. The need for the strongest of ties in co-operation in planning for all these needs requires no emphasis.

School and environmental health services, including the control of

infectious diseases (requiring special arrangements with district councils) should continue at their present satisfactory standards. The time honoured office of medical officer of health will cease, together with the many statutory functions, and while those already employed in the public health service are acquainted both with local authority staffing and structure and have established a relationship with its officers, unless a strong and workable system of collaboration is initiated and maintained from the outset, there could be a deterioration when doctors lacking any local authority experience take their place as community physicians.

TRAINING FOR REORGANISATION

Immediately preceding reorganisation short courses in medical administration and integration of medical care have been set up by the Department of Health and Social Security for those already employed in administration of health services. The former, as recommended by the Working Party on Medical Administration, 1970 (Hunter Committee) are for doctors, while the latter include all those disciplines involved in health care.

CONCLUSIONS

The reorganisation of the National Health Service will mark another era in health care in the United Kingdom. The introduction of planning cycles using broad guidelines against known constraints should result in a greater sense of direction of health care planning and cohesion of all services. The opportunity will be given, for the first time, for members of the medical profession to identify what they believe to be the real health needs of the population and how they may best be met from the limited resources (money, manpower, material) available. The community physician as a member of the team at all levels will have an essential role to play. Initially his objective should be to concentrate on subjects which call for his particular expertise maintaining his present preventive activities together with the efficient collaboration with local authorities. His knowledge of statistics, epidemiology, the organisational aspects of medical care and the development of medical information systems can all provide vital components in the successful operation of the reorganised National Health Service.

THE NEW STATUTORY BODIES
RESPONSIBLE FOR N.H.S. ADMINISTRATION.

Title	Main Functions	Method of Appointment	Accountability
1. Regional Health Authorities (RHAs)	a. Regional planning and policies;	Chairman: by Secretary of State	Secretary of State
	b. Allocation of resources between AHAs;	Members: by Secretary of State after consultation with l.a's, universities, health professions, TUC, voluntary organisations, other interested bodies	
	c. Monitoring of performance of AHAs;		
	d. Executive and operational functions which need to be undertaken on a wider basis than area (inc. responsibility for major capital works, metropolitan county ambulance services, computer services);		
	e. Employment of medical consultants and senior registrars except in "teaching areas" (see 3 below).		
2. Area Health Authorities (AHAs)	a. Area planning policies;	Chairman: by Secretary of State	RHA (except for 2e, for which accountability is to the Secretary of State)
	b. Operation of all services (except for those referred to at 1 d.)	Members (usual pattern): local authority(ies) (statutory minimum)	

Title	Main Functions	Method of Appointment	Accountability
	c. Collaboration with local authorities	1 by RHA on nominations of university	
	d. Employment of staff for those purposes (except for those at 1 e.)	9 by RHA after consultation with professions and interested organisations (including federations of workers or organisations)	
	e. Arrangements with family practitioners		
3. Area Health Authorities (Teaching) (AHA(T)s)	a. As for other AHAs	As for other AHAs but with 1 or 2 additional members appointed on the nomination of universities and with additional appointments of members with teaching hospital experience	As for other AHAs
	b. Provision for university of substantial clinical teaching facilities		
	c. Employment of consultants and senior registrars		
4. Family Practitioner Committees (FPCs)	Administration of arrangements for family practitioner services	Chairman appointed by and from among members 11 members appointed by AHA (at least 1 to be a member of the AHA) 4 members appointed by matching local authority(ies) 15 members appointed by the professions involved.	Secretary of State AHA

